

Ten minutes with Dr Hong Fung, CEO, Chinese University of Hong Kong Medical Centre



FIRST AND FOREMOST, ARE THERE ANY KEY LEADERSHIP MESSAGES YOU WANT TO GET OUT TO OUR READERSHIP?

Communicate, communicate, communicate. During the pandemic, at this time of great uncertainty, it is most important that the leader is able to communicate openly and effectively with his or her team, with staff in the hospital, and with members of the community. Timely and candid communication—on the progress of the outbreak at a local level, how we are going to protect staff and the community, our strategies to ensure adequate supplies of personal protective equipment (PPE), progress on the treatment of sick patients, and our use of isolation facilities—is of the utmost importance, to build trust and solidarity, provide psychological support, align expectations and strengthen team spirit in fighting a long drawn-out battle.

TELL US A LITTLE BIT ABOUT YOUR LEADERSHIP ROLE AND HOW IT IS CHANGING AS A RESULT OF THE PANDEMIC?

I am not currently directly involved in the ‘battlefield’. But I am the CEO [Chief Executive Officer] of the Chinese University of Hong Kong Medical Centre (CUHKMC), which is a new university teaching hospital in its planning stages, expected to open later this year, and I am also a professor of public health and primary care. Over the past year, at CUHKMC, we have started to run a specialist outpatient clinic in a central business area in Hong Kong. Hong Kong was able to contain the outbreak very well at the start of the pandemic, when it was principally affecting mainland China. We have set up a website to communicate all aspects on the COVID-19 epidemic and advise the Hong Kong public what to do to protect themselves. I also participate in various WhatsApp groups of doctors, to share my previous experiences of the 2003 severe acute respiratory syndrome (SARS) outbreak, and the learning from it.

As the COVID-19 disease outbreak has turned into a pandemic, many Hong Kong citizens have returned home from abroad, and many have tested positive. This has caused great anxiety in the community, and increasing stress on the public hospital system, especially on the availability of isolation facilities. At CUHKMC we are rapidly changing our role,

Biography

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to provide timely and fast-track support to corporates and individuals that are not considered high risk by the government, offering viral testing, individual consultation, and occupational and environmental hygiene assessment and advice. We are also actively exploring how we can contribute to the effort once our new building is ready.

WHAT EVENTS IN YOUR PAST EXPERIENCE ARE MOST INFORMING YOUR LEADERSHIP IN THIS PANDEMIC?

I was the Cluster Chief Executive of the New Territories East Cluster—comprising seven public hospitals—and was Hospital Chief Executive of the Prince of Wales Hospital (PWH) in 2003, when the severe acute respiratory syndrome (SARS) epidemic started right in my hospital. Back then, it took us much longer—several weeks—to identify the SARS coronavirus (SARS-CoV), compared with the speed with which Chinese colleagues identified and sequenced the virus (officially designated SARS-CoV-2) that causes COVID-19. This meant that during the first few weeks of the SARS outbreak, testing for the virus was not available; there were virtually no proper isolation facilities in the public hospitals in Hong Kong; and professionals were uncertain as to what PPE they should use. As a consequence, staff were in a state of great anxiety and did not know how best to protect themselves. We learned that it is important to be very transparent about the levels of PPE required, what is needed when, what is the stock of PPE and what the supply process is.

Eventually the outbreak was controlled, but by the end of it, approximately 1500 people had been infected and hospitalised, and some 300 of them had died. As a disease, SARS was more lethal, though less transmissible, than COVID-19. The spread of SARS-CoV depended more on ‘super-spreaders’ and

aerosol-generating procedures, whereas with SARS-CoV-2, we are also very worried about transmission by asymptotically infected individuals.

After the outbreak, as a leader I attended three review panels including the Select Committee under the Legislative Council. All three reports¹ pointed to system-level inadequacies in infectious diseases capacity, contingency responses and communication—including how isolation can affect communication with patients and their relatives—and crisis communication during the epidemic. We quickly implemented all the recommended measures, and Hong Kong has conducted regular drills since to simulate and combat major infectious disease outbreaks. In 2009 during the H1N1 pandemic, Hong Kong was only mildly affected, but all our enhanced systems were well tested. All of these experiences are highly relevant to all stages of the COVID-19 pandemic.

WHAT ARE YOU FINDING THE BIGGEST CHALLENGES?

The biggest challenge is always the politics, it was in 2003 and it is in 2020. In Hong Kong, the 2019 social unrest has eroded many people's trust in the government. But in response to COVID-19, the government has wisely been quick to set up an expert panel, with public health experts and clinical leaders to advise on strategies and action plans, and is providing daily media briefings. Whatever the level of people's trust in government, they do trust what the experts say and follow their advice, including the need to reduce cross-border travel, wear face masks in public areas, practise good hand hygiene and cooperate with quarantine arrangements. However, the difficulty of trust in government is aggravated by the rapid spread of misinformation on social media. Hearsay, rumour and fake news all spread quickly. As the Director-General of the World Health Organisation put it, "...we're not just fighting an epidemic; we're fighting an infodemic. Fake news spreads faster and more easily than this virus, and is just as dangerous."²

ANY PARTICULAR SURPRISES?

I thought that our healthcare workers would be ready for all the challenges of this pandemic, given our experiences of SARS in 2003 and influenza H1N1 in 2009. It turned out that was not the case. The young doctors and nurses playing a key front-line role today were just primary school or junior secondary school students during the time of SARS. Their psychological preparedness for major infectious disease outbreaks, especially when it could affect their own health and lives, has simply not been there. Some of my colleagues who experienced SARS have suggested that the current generation of young professionals is emotionally less mature than the older generations. But of course, these sorts of comments always arise when we look at intergenerational attitudes! The key point is that we are reminded that while the system can learn, the people that make up the system are constantly being renewed. We cannot assume that past experiences will automatically inform the attitudes and behaviours of the newer people.

ARE YOU SEEING ANY BEHAVIOURS FROM COLLEAGUES THAT ENCOURAGE OR INSPIRE YOU?

Once again, the clinicians at PWH have played an exemplary role. As they did in the SARS outbreak, they have been organising themselves into two kinds of team, a 'clean' team dealing with uninfected patients and a 'dirty' team who volunteer to work in the high-risk infectious diseases isolation wards. We set up this model

during the SARS outbreak, initially thinking that we would rotate teams on and off the infected wards. We thought that rotation of this kind would prevent staff from getting fatigue, or burn-out, from working for prolonged periods under high-risk conditions. But we discovered that once staff have adequate PPE, feel safe and understand how to keep themselves safe (for example during aerosol-generating procedures and when taking off their PPE), then they do not want to rotate. They would rather remain in a stable team—not just doctors and nurses, but also clerks and cleaners—where they can all look out for each other. So much so that in the current COVID-19 outbreak, the 'dirty' team has renamed itself as the 'super' team! Of course, in some environments, like accident and emergency, the patients are not segregated and you have to have multiple teams working in rotation; but it is still highly beneficial to keep teams together as much as possible.

HOW ARE YOU MAINTAINING KINDNESS AND COMPASSION?

I communicate our support measures to front-line colleagues all the time. As a senior executive, I make sure I do not just attend contingency response meetings; I get out of the office and I go to the wards every day to talk to front-line colleagues and understand their difficulties and concerns. I track the clinical progress of patients, especially if a healthcare worker gets infected. During these epidemics (SARS, influenza H1N1 and now COVID-19), I find myself practising more servant leadership than at any other time, notwithstanding that I also have to make lots of decisions, and exercise more command and control, than is usual. Building strong relationships by being visible 'on the battlefield' is good for everyone's trust and confidence, but it also sets a good foundation for dealing with the aftermath, as the pandemic wanes and people really start to come to terms with everything that has happened.

ARE THERE ANY IDEAS OR READINGS THAT YOU FIND HELPFUL FOR INSPIRATION AND SUPPORT THAT YOU WOULD RECOMMEND TO OTHERS?

I was very impressed with a book by Gina Kolata called *Flu*, written about the 1918 influenza pandemic,³ but relevant to the 2009 influenza pandemic and future influenza pandemics likely to come. It is really worth a read.

WHAT ARE YOU LOOKING FOR FROM YOUR LEADERS?

As a leader, I have experienced many crises that challenged the health system. SARS and the current pandemic are two examples. I have been able to win support from my colleagues by always giving them my best support, being honest with them, empathising with their difficulties, and walking through the hardship together with them.

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